Alabama Medicaid Agency

501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624

www.medicaid.state.al.us
e-mail: almedicaid@medicaid.state.al.us
TDD: 1-800-253-0799
(334) 242-5000

DON SIEGELMAN
Governor

MICHAEL E. LEWIS
Commissioner

November 27, 2000

PROVIDER NOTICE 00-22

TO: Physicians
Durable Medical Equipment (DME) Medicaid Providers

SUBJECT: Oxygen Therapy Coverage

Effective December 1, 2000, in addition to oxygen therapy coverage for children, the Alabama Medicaid Agency will provide reimbursement for oxygen therapy for adults in the home.

Oxygen Therapy is a covered service based on medical necessity and requires prior authorization. Requests (see attached forms) for coverage must be received by EDS within seven State working days after the oxygen equipment is dispensed. In order to receive a prior authorization number, both forms must be completed and submitted to EDS. Oxygen therapy is based on the degree of desaturation and/or hypoxemia. To assess patient's need for oxygen therapy, the following criteria must be met:

a. The medical diagnosis must indicate a chronic debilitating medical condition, with evidence that other forms of treatment (such as medical and physical therapy directed at secretions, bronchospasm and infection) were tried without success, and that continuous oxygen therapy is required. **Oxygen will not be approved for PRN use only.**

b. Recipients must meet the following criteria:
   1. Adults with a current **ABG** with a **PO2 at or below 59 mm Hg** or an **oxygen saturation at or below 89 percent**, taken at rest, breathing room air. If the attending physician certifies that an ABG procedure is unsafe for a patient, an oximetry for SaO2 may be performed instead. Pulse oximetry readings on adults will be considered only in unusual circumstances. Should pulse oximetry be performed, the prescribing physician must document why oximetry reading is necessary instead of arterial blood gas.
   2. Recipients 20 years old or less with **a SaO2 level:**
      - **For ages birth through three years, equal to or less than 94%**
      - **For ages four and above equal to or less than 89%**

c. The physician must have seen the recipient and obtained the ABG or SaO2 **within 30 days** of prescribing oxygen therapy. Prescriptions for oxygen therapy must include **all of the following**:
   1. type of oxygen equipment
   2. oxygen flow rate

3. concentration level
4. frequency and duration of use
5. estimate of the period of need
6. circumstances under which oxygen is to be used

d. The initial approval is based on medical necessity for no more than three months. To renew approval, ABG or SaO2 is required within 30 days of the end-date of the initial approval period. Approval for up to 12 months will be granted at this time if resulting ABG values or SaO2 levels continue to meet criteria. If ABG or SaO2 is not obtained within the 30-day period, approval will be granted beginning with the date of the qualifying ABG or SaO2 reading.

e. Criteria for equipment reimbursement
   1. Oxygen Concentrators will be considered only for large volume users. Prior approval requests will automatically be reviewed to determine if a concentrator will be the most cost effective method of administration.
   2. Reimbursement will be made for portable O2 only in gaseous form. Medicaid will cover portable oxygen for limited uses such as physician visits or trips to the hospital. This **must** be documented on the medical necessity or prior approval request. Portable systems that are used on a standby basis only will not be approved. **Only one tank per month will be approved.**
   3. Medicaid will reimburse for only one stationary system at a time.
   4. **The DME supplier or a related corporation may not perform the ABG study or oximetry analysis used to determine medical necessity.**

Please refer to the Alabama Medicaid Provider Manual, Chapter 14, for procedure code coverage.

Questions regarding this provider notice should be directed to the Long Term Care Provider/Recipient Management Unit at (334) 242-5657.

Michael E. Lewis
Commissioner

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Attachments

Distribution:

Alabama Durable Medical Equipment Association	Medical Association of the State of Alabama
Alabama State Medical Association	Alabama Hospital Association
Alabama Medicaid Agency Staff	Electronic Data Systems (EDS)

REMINDER: All Medicaid recipients are required to present their Medicaid eligibility card and proper identification to a provider of medical care of services for verification of eligibility when seeking treatment or service under the Medicaid program.

Alabama Medicaid Agency

Oxygen Therapy

Request for Prior Authorization and Prescription

Patient Information

Patient Name: _____ Patient Medicaid Number: _____

Date of Birth: _____ Diagnosis: _____

Prescription Information

Date last seen by physician: _____

Date oxygen prescribed: _____ □ Initial □ Renewal

Liters per minute: _____ Minutes per hour: _____ Hours per day: _____

Method of delivery (nasal cannula, mask, etc.): _____

If portable oxygen prescribed, state purpose: _____

Estimated length of time oxygen needed: _____ (months)

Describe type, duration, and frequency of recipient's daily activities outside the home:

_____

_____

Equipment Prescribed

Stationary System

- ❑ Compressed Gas
- ❑ Oxygen Concentrator

Portable System

- ❑ Compressed Gas

Laboratory Results

ABG (PO2) result _____ □ Room Air □ Oyxgen Date of test: _____

Oxygen Saturation _____ □ Room Air □ Oyxgen Date of test: _____

Must attach a copy of the ABG report or oxygen saturation readout. ABG not required for children.

If ABG was not performed, please explain: _____

If test not performed on room air, please explain: _____

If ABG exceeds 59 mm Hg or if oxygen saturation exceeds 89 percent **(94 percent for children three and under**), physician must justify need for oxygen with more medical information.

_____

_____

_____

(A separate letter may be attached if more space is needed to justify medical necessity)

The request for prior authorization must be submitted within seven (7) working days of the beginning of the service. All requests received beyond this time frame will be authorized for reimbursement effective the date of receipt by EDS.

I certify that oxygen is medically necessary.

Physician Signature: _____ Date: _____

(Stamped signatures are not acceptable)

ALABAMA PRIOR REVIEW AND AUTHORIZATION REQUEST

(Required If Medicaid Provider) PMP ( )

Requesting Provider
License # or Provider # _____

Phone ( ) _____

Name _____

Recipient Medicaid Number_____

Name _____

Address _____

City/State/Zip _____

Rendering Provider Medicaid # _____

Phone ( )_____

Fax ( )_____

Name _____

Address _____

City/State/Zip _____

Certification ___ Yes __ No

Recertification/Continued Stay ___ Yes __ No

Date of EPSDT Screening CCYYMMDD _____

Date of Prescription CCYYMMDD _____

First Diagnosis _____ • ____ Ambulance Transport Code ____

Second Diagnosis _____ • ____ Ambulance Transport Reason Codes ____

PA Type_____ Patient Condition _____

(01) Durable Medical Equipment	(06) Physical Therapy	(11) Drugs	(16) Oxygen
(02) Eyeglasses	(07) Speech Therapy	(12) Medical	(17) Prosthetic Devices
(03) Home Health	(08) Private Duty Nursing	(13) Psychiatric*	(18) Inpatient Stay *
(04) Transportation	(09) Ultrasound	(14) Customized Wheelchairs	
(05) Occupational Therapy	(10)Targeted Case Mgt	(15) Surgical	(19) Other

Line Item	DATES OF SERVICE START CCYYMMDD	STOP CCYYMMDD	PLACE OF SERVICE	PROCEDURE CODE*	MODIFIER 1	UNITS	PRICE/ DOLLARS

Clinical Statement: (Include Prognosis and Rehabilitation Potential) A current plan of treatment and progress notes, as to the necessity, effectiveness and goals of therapy services (PT, OT, RT, SP, Audiology, Psychotherapy, Oxygen Certifications, Home Health and Transportation) must be attached.

_____

_____

_____

_____

_____

_____

*** If this PA is for Psychiatric or Inpatient stay, Procedure Code is not required.**

Certification Statement: This is to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient and that a physician signed order is on file (if applicable). This form and any statement on my letterhead attached hereto has been completed by me, or by my employee reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Requesting Provider_____ Date_____

FORWARD TO: EDS, P.O. Box 244036 Montgomery, Alabama 36124-4036

Form 342 1/00

Alabama Medicaid Agency